MARYLAND STATE DEPARTMENT OF HEALTH

11698

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
31 Washington Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 31 Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Duvall Adams

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 2, 1862

8. AGE: Years	Months	Days	If less than one day
84	1	5	..... hrs. ..... min.

9. Birthplace: Bowie Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Gaberial Duvall
13. Birthplace: Bowie Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Bowie Maryland

16. Informant: Samuel Adams
Address: 31 Washington Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-11-1946 (month) (day) (year)
Cemetery or crematory: St, Marys
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Dec. 10, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7, 1946, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 15 1946, to Dec 7, 1946
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Myocarditis	Since May 15
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: R. S. Richardson MD
M. D. or other
Address: Annapolis Md Date signed 12/10/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-8)

CERTIFICATE OF DEATH

11699

Reg. Dist. No. 21-0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Mc Kendree Ave
(If outside city or town limits, write RURAL and give nearest town)

Street No. Annapolis Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Howard Amoss

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Viola W. Amoss

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 16th 1882

8. AGE: Years: 64 | Months: | Days: 2 | If less than one day: ... hrs. ... min.

9. Birthplace: Howard Co Md.
(Town, county, and state)

10. Usual occupation: Ret. Employee U. S.

11. Industry or business: Exp. Station Annapolis Md.

FATHER — 12. Name: Benj H. Amoss

13. Birthplace: Howard Co Md

MOTHER — 14. Maiden name: Mary Kroner

15. Birthplace: Catonsville Md.

16. Informant: John R. Amoss

Address: Exp. Station Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 21-1946 (month) (day) (year)

Cemetery or crematory: St Annes

Location: Annapolis Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. Dec 21 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18 19 46, at 1.22 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 46, to Dec 18 19 46, and that I last saw h. alive on Dec 18 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 12 hrs.
Due to: Hypertensive C.V. disease.	
Due to:	
Other conditions: Carcinoma Stomach	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca. Stomach

Date of op. 12/16/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Lamont Loest M. D. or other

Address: Laurel Md Date signed 12/19/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

11700

Reg. Dist. No. 21 0

1. PLACE OF DEATH:

County: Anne Arundel

City or town: ~~Athens~~ Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 92 Conduit St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Anderson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary E. Anderson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 4th 1859

8. AGE:

Years	Months	Days	If less than one day
87	8	23	..... hrs. ..... min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Ret Civil Service

11. Industry or business: U.S.N. Academy Annapolis

FATHER 12. Name: Unknown

FATHER 13. Birthplace

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace

16. Informant: Bernard Anderson

Address: 92 Conduit St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 1946 (month) (day) (year)

Cemetery or crematory: St Annes

Location: Annapolis Md.

18. Funeral director: John W. Taylor Co. Inc

Address: Annapolis Md.

19. Dec 30 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1946, at 3 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1945, to Dec 27 1946

and that I last saw him alive on Dec 27 1946

Immediate cause of death	DURATION
Myocardial Degeneration	2 yrs
Due to: Myocardial Insufficiency	
Due to:	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... injured at work?

23. SIGNATURE: George C. Basil M. D. or other

Address: Annapolis Md. Date signed: 12-29-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11701

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 102 Monticello Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret E. Black

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Col. Roger D. Black
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 10th 1884

8. AGE:

Years	Months	Days	If less than one day
62	2	10	hrs. min.

9. Birthplace: Portland Maine
(Town, county, and state)
10. Usual occupation: House
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Richard W. Black
Address: 102 Monticello Ave Annapolis Md.
17. Removal Date thereof Dec 21 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: West Point
Location: West Pt. New York
18. Funeral director: John M. Sadler Co.
Address: Annapolis Md.
19. Dec 22 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1946, at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4th 1946, to Dec 20 1946
and that I last saw her alive on Dec 19 1946

Immediate cause of death	DURATION
Cerebro Vascular Failure	Indefinite
Due to: Coronary Thrombosis	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Oliver Purdie M. D. or other
Address: Annapolis Md. Date signed: 12/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

11704

BC

Reg. Dist. No. 280

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1yr, 4 mo., 22 da.

Hospital, Institution, or street address where death occurred:
Feebleminded Division of Crownsville St. Hos

How long in hospital or institution? 1 yr, 4 mo., 22 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. ———
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3. (a) FULL NAME: EARL BROWN

3. (b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) ——— 1925

8. AGE:

Years	Months	Days	If less than one day
21	———	———	——— hrs. ——— min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: ———

FATHER
12. Name: ———
13. Birthplace: ———

MOTHER
14. Maiden name: ———
15. Birthplace: ———

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof 12-17-46 (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville, Maryland

18. Funeral director: Crownsville State Hospital
Address: Crownsville, Maryland

19. Dec 17 19 46 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 19 46 at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 19 45 to Dec. 14 19 46 and that I last saw him alive on December 14 19 46

Immediate cause of death	DURATION
Diffuse peritonitis	
known to us 3	days
Due to	
Due to	
Other conditions: Psychosis with mental deficiency	

(Include pregnancy within 3 months of death)

Major findings of operation: ———— Date of op. obstruction

Autopsy results: diffuse peritonitis & intestinal

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Herbert J. Pinkerton M. D. or other

Address: Crownsville, Maryland Date signed 12/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

11702

Reg. Dist. No. 27C

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Army Area Regional Station Hospital, Fort George G. Meade, Md.
How long in hospital or institution? 3/4 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: HOWARD
City or town: Simpsonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: OWEN T. BROWN

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Olive P. Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JAN. 19, 1887

8. AGE:

Years	Months	Days	If less than one day
59	10	24	hrs. min.

9. Birthplace: ATHOLTON Md. (Town, county, and state)
10. Usual occupation: CLERK.
11. Industry or business: FORT GEO. G. MEADE
12. FATHER Name: RICHARD H BROWN
13. Birthplace: MARYLAND
14. MOTHER Maiden name: MARY E WHIPPS
15. Birthplace: MARYLAND.
16. Informant: MRS OLIVE P BROWN
Address: SIMPSONVILLE Md.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12-16-46 (month) (day) (year)
Cemetery or crematory: LINTHICUM CHAPEL
Location: CLARKSVILLE, Md.
18. Funeral director: F.C. HIGINBOTHOM
Address: ELLICOTT CITY, Md.
19. 13 December 1946 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., MC, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 December 1946, at 1315P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 13 December 1946 to 13 December 1946 and that I last saw him alive on 13 December 1946

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 hour
Due to: Hypertensive cardiovascular disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Carleton S. Herrick Jr. CARLETON S. HERRICK, JR., M. D. (M. D. or other)
Address: Reg Sta Hosp, Ft. G. G. Meade, Md. Date signed: 13 Dec. 46.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

11703

Reg. Dist. No. 286

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo., 28 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1810 Bragwood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: JOSEPH BURRELL

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ———
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
67	---	---	... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: ———

FATHER
12. Name: Basil Burrell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Frances ?
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec 28 46 (month) (day) (year)
Cemetery or ~~crematory~~: Hospital Cemetery
Location: Crownsville Md
18. Funeral director: Supt. Hospital
Address: Crownsville Md

19. 12/28 46 E. F. Joyce Local
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1946, at 6:05 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1946, to Dec. 20 1946 and that I last saw him alive on Dec. 20 1946

Immediate cause of death	DURATION
General Paresis	known to us since 5/23/46
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ——
Where did injury occur? ———
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Albert V. Matthews
M. D. or other
Address: Crownsville, Maryland Date signed: 12/21/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

11705

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:
County A. A. C.
City or town Shadmore A. A. Co.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Shadmore A. A. Co.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Carr Carr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife Lourinda Carr.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 5 1876

8. AGE: Years 70 | Months 6 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Shadmore (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name William Carr
13. Birthplace Md.

MOTHER
14. Maiden name Harried Thomas
15. Birthplace Md.

16. Informant Louis Carr
Address R.F.D. 2 Box 266 Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 18 1946 (month) (day) (year)
Cemetery or crematory Broadneck
Location St. Margarets, A. A. Co.

18. Funeral director J. B. Johnson
Address Annapolis Md

19. Dec. 18, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1946, at 6.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-2 1946, to Dec 15 1946
and that I last saw h[illegible] alive on Dec 8, 1946

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to Portal Freezing	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. T. Allen M.D.
Address 17 Carroll St. M. D. or other
Date signed Dec 16 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1952)

CERTIFICATE OF DEATH

★ 11706 Reg. Dist. No. 201

1. PLACE OF DEATH:

County Anne Arundel

City or town Rural - Harwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:
Route #2 (Md.) nr. Harwood

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eleanor May Chesser

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 June '46

8. AGE:

Years	Months	Days	If less than one day
0	5	22	hrs. min.

9. Birthplace Annapolis A.A., Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name James Haskew Chesser
13. Birthplace Luverne, Ala.

MOTHER
14. Maiden name Margaret Elizabeth Taylor
15. Birthplace Bristol, A.A., Md.

16. Informant Mrs. Eleanor Taylor
Address Harwood, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Dec 5/46
(month) (day) (year)

Cemetery or crematory Episcopal
Location Queensville Md

18. Funeral director B. L. Riggin & Son
Address Annapolis Md

19. Dec. 3 1946
(Date rec'd by registrar)
W. Clyde
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Dec. 1946 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
~~19~~ to ~~19~~
~~and that I last saw him~~ alive on 19

	DURATION
Immediate cause of death Cardiorespiratory failure	
Due to Asphyxia	
Due to Regurgitation & inhalation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward P. Ritchie, M.D.
M.D., or other
Acting M.E.

Address 199 Gloucester St. Annapolis, Md. Date signed Dec. 1, 1946

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

11767 B

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years - 10 months

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 12 years - 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore County
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME: CLARK - JOBE ARMON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1892

8. AGE: Years	Months	Days	If less than one day
54 1892	——	——	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Henry Clark
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachel Blake
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Buriol, cremation, or removal. Which?) Date thereof Dec. 31, 1946 (month) (day) (year)
Cemetery or crematory: Bethlehem Child
Location: Baltimore, Rd. Md.

18. Funeral director: Thos. Lee H. Hartland
Address: 631 Druid Hill Ave.

19. Dec 28 1946 (Date rec'd by registrar) A. St. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28, 1946 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1935 to December 28, 1946 and that I last saw him alive on December 28, 1946

Immediate cause of death: Psychosis with Convulsive Disorders (Epilepsy) — DURATION: Know to us since admission

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Neal S. Winkelried M. D. or other

Address: Crownsville, Maryland Date signed: 12/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11708

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 26 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: ----- Cambridge (If outside city or town limits, write RURAL and give nearest town)
Street No.: ---------- (If rural, give LOCATION)
2.(a) If veteran, name war: ---------- ✓

3.(a) FULL NAME: ANNIE CORNISH

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: ----- years
7. Birth date of deceased (mo., day, yr.): 1888 ?

8. AGE: Years	Months	Days	If less than one day
58 ?	--	--	..... hrs. ..... min.

9. Birthplace: -------- (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: ------

FATHER
12. Name: ---
13. Birthplace: -----

MOTHER
14. Maiden name: ----
15. Birthplace: ----

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 19, 1946 (month) (day) (year)
Cemetery or crematory: Cambridge
Location: Cambridge, Maryland

18. Funeral director: Louis H. Bayneum
Address: Cambridge, Maryland

19. Dec. 17 1946 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1946 at 8:00P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 1946 to Dec. 16 1946 and that I last saw her alive on December 16 1946

Immediate cause of death	DURATION
General Arteriosclerosis	known to us since 10/21/46
Due to	
Due to	
Other conditions: Senility without psychosis known to us since 10/21/46 (Include pregnancy within 3 months of death)	

Major findings of operations: ------
Date of op.: ----
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: ----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---------
Means of injury: ------ Injured at work? ---

23. SIGNATURE: Albert J. Whitehead M. D. or other
Address: Crownsville, Maryland Date signed: 12/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

11769 P

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessups (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2709 Gibbons Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mary Ellen Paris -

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wt	married

6.(b) Name of husband or wife: Charles Lee Paris

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Nov 21 1863

8. AGE: Years	Months	Days	If less than one day
83	1	3	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: James Paris Pamela

13. Birthplace: Baltimore Md

MOTHER 14. Maiden name: Elizabetha Beck

15. Birthplace: Maryland

16. Informant: Lenna L. Wright

Address: Jessups, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 29, 1946 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Taylor Ave.

18. Funeral director: Leonard J. Rusk

Address: 5305 Harford Road

19. 12/26 1946 (Date rec'd by registrar) Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1946, at 5:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1946, to Dec 24 1946

and that I last saw h[illegible] alive on Dec 24 1946

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Carbon Monoxide	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Jessups, Md Date signed: Dec 24 '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11710

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Hanover (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred: Ridge Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Hanover Md (If outside city or town limits, write RURAL and give nearest town)
Street No. Ridge Rd, R.F.D. Box # (If rural, LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary E. Dehn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: August A. Dehn
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26 - 1877

8. AGE: Years 69 Months 4 Days 10 If less than one day hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Housework

FATHER 12. Name: Geo W. Snook
FATHER 13. Birthplace: Md

MOTHER 14. Maiden name: Elizabeth A.
MOTHER 15. Birthplace: Md

16. Informant: Mrs Viola Arnold (Daughter)
Address: R.F.D. #3 Cambridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Baltimore, Md.

18. Funeral director: A. Howard Evans
Address: 1400 E. Chas St., Balto. 30, Md.

19. 12/7 19 46 A. H. Kedrick per E.B. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 19 46 at 1 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 46 to Dec 6 19 46 and that I last saw him alive on Dec 6 19 46

	DURATION
Immediate cause of death: Bronchio-Pneumonia	6 da.
Due to: Myocardial Insufficiency	6 da.
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. M. Brumbaugh M. D. or other
Address: Edgewood Md Date signed: 12/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-d)

CERTIFICATE OF DEATH

11711

Reg. Dist. No. 26-250

1. PLACE OF DEATH: Anne Arundel
County
City or town Brooklyn, Baltimore 25
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Brooklyn, Baltimore 25,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 606 Woods
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joyce Lynn Dews.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1946.

8. AGE:

Years	Months	Days	If less than one day
	3	8	..... hrs. ..... min.

9. Birthplace Brooklyn, Baltimore 25, Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Judson Lee Dews
13. Birthplace Georgia

MOTHER
14. Maiden name Ernestine Blanke
15. Birthplace Red Cloud, Nebraska.

16. Informant Judson L. Dews
Address Brooklyn, Baltimore 25 Md

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 12/11/46 (month) (day) (year)
Cemetery or ~~crematory~~ Glen Haven
Location Glenburnie Md.

18. Funeral director William Cook Inc.
Address 1217 St. Paul St.

19. 12-10 1946 M. Kendrick
(Date rec'd by registrar) Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1946, at 12 25 P. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
Post mortem Examination 19—
and that I last saw ~~him~~ ~~alive~~ on Dec. 9 1946

Immediate cause of death	DURATION
Strangulation	
Due to Regurgitation of	
~~Due to~~ Pom Pas	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 12/9/46
Where did injury occur? Brooklyn (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) home
Means of injury as above described Injured at work?

23. SIGNATURE John M. Cathy M.D Deputy Medical Examiner
M. D. or other
Address Annapolis Md. Date signed 12/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Q. Klemans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

11712

Reg. Diet. No. 21 0

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Larkin St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William H. Dorsey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widower

6.(b) Name of husband or wife: Lillian Dorsey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE: Years: 72 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Annapolis, Md.
(Town, county and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: William H. Dorsey
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Elizabeth Jones
15. Birthplace: Calvert Co.

18. Informant: Wm. E. Dorsey

Address: Parole md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3, 1947 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Annapolis, Md.

18. Funeral director: J. B. Duncan

Address: Annapolis, Md.

19. Jan. 3 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31 1946, at 1100 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Dec. 31 1946 and that I last saw him alive on Dec. 30 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days.
Due to: General arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: M. J. Klemans, M.D.
M. D. or other

Address: 31 Southgate Ave. Date signed: 1/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

11713

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A.A.
City or town Bay Ridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6Years
Hospital, Institution, or street address where death occurred:
Hull Ave
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A.A.
City or town Bay Ridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hull Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie M. Eastman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife George A. Eastman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 23 1874

8. AGE: Years	Months	Days	If less than one day
71	11	26	..... hrs. ..... min.

9. Birthplace Hopbottom. Pa. (Town, county, and state)
10. Usual occupation None
11. Industry or business M. Woolsey
FATHER 12. Name Sylvester
13. Birthplace PA.
MOTHER 14. Maiden name Dian Harvley
15. Birthplace Pa.
16. Informant Miss May B. Eastman
Address Bay Ridge Ave Ba Hull Ave.
17. Cremation (Burial, cremation, or removal, Which?) Date thereof Dec 19 1946 (month) (day) (year)
Cemetery or crematory Fort ~~Lincoln~~ Lincoln
Location Hyattsville. Maryland
18. Funeral director B.L.Hopping & Son
Address Annapolis, Maryland.
19. Dec 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1946, at 2 47 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1946, to Dec 19 1946
and that I last saw h~ alive on Dec 17 1946

	DURATION
Immediate cause of death Cardio Vascular Failure	24 hrs
Due to Arteriosclerosis	several yrs.
Due to Chr. Myo Carditis	9 yrs.
Other conditions With Dilatation	about 9 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE J. Oliver Turner, M. D. or other
Address Annapolis Md Date signed 12/19/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

Reg. Dist. No. 11714 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct Age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred: Hill Top School

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Jessup Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. ____ (If rural, give LOCATION)

2.(a) If veteran, name war: ____

3.(a) FULL NAME: John Augustine English Eyster Jr

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 14, 1912

8. AGE: Years: 34 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Madison Wis. (Town, county, and state)

10. Usual occupation: Realtor Invalid

11. Industry or business: —

FATHER — 12. Name: John Augustine English Eyster

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Mary Adams

MOTHER — 15. Birthplace: Virginia

16. Informant: Mrs F. K. Moore

Address: Jessup Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 26/46 (month) (day) (year)

~~Cemetery or~~ crematory: London Park Greenmount

Location: Baltimore, Md.

18. Funeral director: John L. Mitchell & Sons, Inc.

Address: 1900 Eutaw Place, Balto.

19. Dec 26 1946 (Date rec'd by registrar) A. W. Kenerly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1946 at 11 22 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1946, to Dec 24 1946 and that I last saw h. alive on Dec 24 1946

Immediate cause of death	DURATION
Pulmonary Thrombosis	4 da
Due to Streptococcus Pneumonia (Hemolytic)	4 da
Due to Mongoloid Idiot	Life
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkridge Md Date signed: 12/24/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11715

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 232 Prince Geo St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Dawes Feldmeyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles J. Feldmeyer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 20th 1852

8. AGE: Years	Months	Days	If less than one day
94	2	16	..... hrs. ..... min.

9. Birthplace Annapolis Md.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Meredith Dawes

13. Birthplace Annapolis, Md.

MOTHER 14. Maiden name Isabella Wells

15. Birthplace Annapolis, Md.

16. Informant Mrs Ethel F. Kung

Address 232 Prince Geo St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8th 1946 (month) (day) (year)

Cemetery or crematory St Anns

Location Annapolis Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md

19. Dec. 8, 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6th 1946 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 6 1946

and that I last saw h. alive on Dec. 6 1946

Immediate cause of death	DURATION
Senility	5 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert R. Anderson M.D.

M. D. or other

Address Annapolis, Md. Date signed Dec 9th 46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11716

Reg. Dist. No. 206

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1.-PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:
Road in Woodland Beach

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Woodland Beach
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Chester F. Foote

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Irma Foote

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1902

8. AGE: Years	Months	Days	If less than one day
44	11	7	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER 12. Name: Albert Foote

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Jane Phipps

15. Birthplace: Maryland

16. Informant: Irma Foote

Address: Woodlawn Beach A.A.Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24th 1946 (month) (day) (year)

Cemetery or crematory: National

Location: Annapolis Md.

18. Funeral director: John M. Taylor, Son

Address: Annapolis Md.

19. Dec. 23 19 46 Edward Collamore Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 19 46, at 1 10 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward P. Ritchings M.D. M. D. or other

Address: 129 Gloucester St. Acting M.E. Annapolis, Md. Date signed: Dec. 24, 1946

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11717

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 6 mo., 4 da.

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 yrs., 6 mo., 4 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore 17 (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1848 Lorman Street (If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME: CARRIE GARRETT

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1924

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
22	--	20		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: ———

FATHER — 12. Name: Emery Garrett

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rosette Harris

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1946 (month) (day) (year)

Cemetery or crematory: Mount Ivory (Crownsville)

Location: Baltimore, Maryland

18. Funeral director: George E. Kelson

Address: Baltimore, Maryland

19. 12-4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1946 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1944 to December 2 1946

and that I last saw her alive on December 2 1946

Immediate cause of death	DURATION
Tuberculosis of both lungs known to us since 5/29/44	
Due to	
Due to	
Other conditions: Schizophrenia known to us since 5/29/44	

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Albert J. Hinkson M. D. or other

Address: Crownsville, Maryland Date signed: 12/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

11718

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: A.A.
City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 Days
Hospital, Institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.a.a.A.a.
City or town: Eastport.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 930 Monroe
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marie A. Goddard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Earnest R. Goddard. Sr
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Dec 16 1895

8. AGE:

Years	Months	Days	If less than one day
51		14	....hrs. ....min.

9. Birthplace: Baltimore. Md.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER
12. Name: Frederick Brandt
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary M. [illegible] Hölkm
15. Birthplace: Germany

16. Informant: Earnest R. Goddard. Sr
Address: 930 Monroe St. Eastport. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2 1947 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Annapolis, Md.

18. Funeral director: B.L.Hopping & Son
Address: 170-172 West Street Annapoilis, Md

19. Dec. 31, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 1946 3.25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1946 to Dec 30 1946
and that I last saw h.. alive on Dec. 30, 1946

	DURATION
Immediate cause of death	
Coronary Thrombosis (Cause Unknown)	Few days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation: Uterine fibroid.
Date of op. 12/18/46.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gilbert L. Anderson M.D.
M. D. or other
Address: Annapolis Md Date signed 12/31/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Martin

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 11719 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
83 College Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 85 College Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ALBERT E. GRAF

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug 5, 1879

8. AGE: Years	Months	Days	If less than one day
67	4	15	... hrs. ... min.

9. Birthplace: Boston, Mass. (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business
FATHER 12. Name: Arthur Craf
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Emma Acheuback
MOTHER 15. Birthplace: Balto. Md.
16. Informant: Mr Charles E. Gates
Address: 83 College Ave, Annapolis, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-23-46 (month) (day) (year)
Cemetery or crematory: St. Anne's Cemetery
Location: Annapolis, Maryland
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland
19. Dec. 23, 1946 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-20- 19 46, at 8 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-20-46 19 ... to 12-20-46 19 46
and that I last saw him alive on 12-20-46 19 ...

Immediate cause of death	DURATION
Coronary Occlusion	2 hrs.
Due to: Myocarditis Chronic	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: James R. Martin, M.D. M. D. or other
Address: 165 Prince George St. Annapolis, Md. Date signed 12-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Slayton give him credit

12588

175c

260

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - near Bristol
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:
Home of Frank Hall near Bristol

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Rural - near Bristol
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: William Gross

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Marie Gross

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1923

8. AGE: Years: 23 | Months: 8 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Harwood A.A. Md.
(Town, county, and state)

10. Usual occupation: Farmhand

11. Industry or business:

FATHER
12. Name: Richard Gross
13. Birthplace: McKendree, Md.

MOTHER
14. Maiden name: Eva Sharps
15. Birthplace: Greenock, Md.

16. Informant: Richard Gross
Address: Harwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7, 1946 (month) (day) (year)
Cemetery or crematory: Adams Lane
Location: Fothian Md
Funeral director: E. A. Hardesty & Son
Address: Galesville Md

19. 12/6 46 (Date rec'd by registrar) 19 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~this~~ 19 to 19
and that I last saw ~~him~~ alive on 19

Immediate cause of death	DURATION
Fracture cervical vertebrae	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Dec. 3, 1946

Where did injury occur? near Bristol (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Farm of Lucy Dorr

Means of injury: Fell off Tractor Injured at work? Yes

23. SIGNATURE: Edward P. Ritchings M.D.
M.D. or other
Address: 199 Gloucester St Date signed: Dec 3 1946
Calling M.E.
Annapolis Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11720

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Herald Harbor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 yrs
Hospital, Institution, or street address where death occurred:
Herold Harbor
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Herald Harbor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ADDA H. HALL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	WIDOWED

6.(b) Name of husband or wife: Joseph E. Hall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1866

8. AGE: Years	Months	Days	If less than one day
80	2	2	2 hrs. ___ min.

9. Birthplace: Youngstown, Ohio (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Sheldow
13. Birthplace: England
MOTHER 14. Maiden name: Charlotte Sutcliff
15. Birthplace:
16. Informant: Mr. Richard S. Hall
Address: Herold Harbor
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-23-46 (month) (day) (year)
Cemetery or crematory: Baldwin Memorial Cemetery
Location: Millersville, Maryland
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West Street, Annapolis, Md.
19. Dec. 23, 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1946, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1946, to Dec 1946
and that I last saw h alive on Dec 19 1946

	DURATION
Immediate cause of death: Myocarditis Chr. Cert	
Myocardial Insufficiency	Unknown
Due to:	
Due to:	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ginger C. Baril, M. D. or other
Address: Annapolis md Date signed: 12-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

11721

2411 N. Charles St., Baltimore (93-P)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 Years

Hospital, institution, or street address where death occurred:
18 Monument Street

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Maryland Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 18 Monument Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: John Thomas Young Hall

3.(b) Social Security Number: 214-14-2658

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): October 17, 1875

8. AGE: Years	Months	Days	If less than one day
71	2	9	... hrs. ... min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ellen Young
15. Birthplace: Calvert Co. Maryland

16. Informant: Robert Chase

Address: 413 Chesapeake Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-30-1946 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Dec. 30, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1946, at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-25 1946, to 12-26 1946 and that I last saw h--- alive on 12-24 1946

Immediate cause of death	DURATION
Congestive heart failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: C. T. Talley M.D. M. D. or other

Address: 17 Carroll Date signed: 12-29-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (75-C)

Registered No. 11728 212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Solley, Anne Arundel Co. Md
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town (RURAL) Solley
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** JAMES ANDREW HAMMOND

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 178-10-8386

4. Sex: MALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: EDNA C.

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1889

8. AGE: Years: 57 | Months: 10 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Altoona, Blair Co Penna
(Town, county, and state)

10. Usual Occupation: Chief Boilermaker

11. Industry or business: Maryland Drydock

FATHER
12. Name: William Hammond
13. Birthplace: Penna

MOTHER
14. Maiden Name: Mary Jane Lohr
15. Birthplace: Penna.

16 (a) Informant (wife) EDNA C. HAMMOND
(b) Address Solley A.A.C, Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 24 1946 (month) (day) (year)
(c) Cemetery or crematory: Calvary
Location: Altoona Pa

18 (a) Funeral director: William Cook Inc
(b) Address: 217 St. Paul st.

19 (a) 12/24/46 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1946, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1946, to Dec 22 1946, and that I last saw him alive on 12/22 1946.

Immediate cause of death	Duration
Cardiac Decompensation	5 years
Due to: Bronchial Asthma	
Due to:	
Other Conditions: Bronchiectasis, Bronchial Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Benjamin H. Lohr Jr. M.D.
Address 310 Fifth Ave Brooklyn NY Date signed 12/32/46

VS 150

1-25

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11723

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one month 21 days
Hospital, institution, or street address where death occurred:
State Hospital Crownsville Md.
How long in hospital or institution? one month 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: /
City or town: Cecilstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: /
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: Charles H. Handy

3.(b) Social Security Number: /

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married (?)

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years	Months	Days	If less than one day
33	/	/	/ hrs. / min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: /

FATHER — 12. Name: James Handy
13. Birthplace: Cecilstown, Maryland

MOTHER — 14. Maiden name: Maggie Jones
15. Birthplace: Washington D. C.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2, 1947 (month) (day) (year)
Cemetery or crematory: Cecilton
Location: Cecilton Md.

18. Funeral director: Edward Fellows
Address: Millington Md.

19. Dec 29 46 (Date rec'd by registrar) E. J. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1946, at 11 55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7th 1946 to December 28 1946
and that I last saw h.im alive on December 28th 1946

Immediate cause of death: General Paresis — DURATION: known to us since about 7th 1946

Due to: /

Due to: /

Other conditions: /

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.: no

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no — Date of: no
Where did injury occur? no (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): none
Means of injury: — Injured at work: no

23. SIGNATURE: Albert J. Hinderer M. D. or other
Address: Crownsville, Md. Date signed: 12/28/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Edward Tellowe
Millington
Md.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (08)

CERTIFICATE OF DEATH

P

Reg. Dist. No. 11723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years.

Hospital, institution, or street address where death occurred: Telegraph Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Severn.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Telegraph Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elvin Hans Hansen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Widowed.

6.(b) Name of husband or wife: Mary E. Doerer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 30 - 1889

8. AGE:

Years	Months	Days	If less than one day
57	1	12	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland.

(Town, county, and state)

10. Usual occupation: Tool maker.

11. Industry or business

FATHER 12. Name: Soren Hansen

FATHER 13. Birthplace: Denmark.

MOTHER 14. Maiden name:

MOTHER 15. Birthplace

16. Informant: Mrs. Julia Fesson, (wife)

Address: Severn, Md.

17. Buried — Date thereof 12/16/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Frederick Rd

18. Funeral director: Lilly & Zech Sr

Address: 403 E. Fairfield

19. 12/16 19 46 Dan Hebert

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1946, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945, to Dec. 12 1946

and that I last saw him alive on 12/12/46 19

Immediate cause of death	DURATION
Lobar Pneumonia	10 days
Due to: Asthma (Bronchial)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Rauhe M.D.

M. D. or other

Address: Island Brevia, Md. Date signed 12/13/46

Evidence for the change of age is shown on G 1081 1/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

11725

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Hill Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Robert H. Harder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Marjorie L. Harder
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 19, 1909

8. AGE: Years	Months	Days	If less than one day
37 36	11	10	..... hrs. ..... min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Forest B. Harder
13. Birthplace: A. A. Co Md.

MOTHER
14. Maiden name: Annie Wells
15. Birthplace: A. A. Co Md.

16. Informant:
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-1-47 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: John H. Layla & Son
Address: 167 Gloucester St.

19. Dec. 30 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 29 1946, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.. alive on Dec 29 - 1946

Immediate cause of death	DURATION
Coronary Thrombosis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Easton Md. Date signed 12/30/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

11726

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 3 College Ave. (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Annie Ridgely Haste

3.(b) Social Security Number: 213-18-6527

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.): November 5, 1892

8. AGE: Years 54 Months 1 Days 16 If less than one day ....hrs. ....min.

9. Birthplace: Anne Arundel Co. Md. (Town, county, and state)

10. Usual occupation: General Housework

11. Industry or business: None

FATHER

12. Name: John W. Ridgley

13. Birthplace: Anne Arundel Co.

MOTHER

14. Maiden name: Siszanna West

15. Birthplace: Anne Arundel Co.

16. Informant: Louise Makel

Address: 43 Washington St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-26-1946 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: West St. Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest St.

19. Dec 26 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1946, at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1946, to Dec 21 1946 and that I last saw her alive on Dec 21 1946

Immediate cause of death	DURATION
Fracture Skull	
Compound Fracture	
Due to: tibia & fibula lower thigh	
Due to: left lower extremity; Automobile accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12/19/46

Where did injury occur? Annapolis (City or town) Maryland (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .... Injured at work?

23. SIGNATURE [signature] M. D., or other

Address: [illegible] Date signed: 12/[illegible]

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

11727

Reg. Diat. No. 280

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs., 5 mo., 27 da.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 34 yrs., 5 mo., 27 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: ———
(If outside city or town limits, write RURAL and give nearest town)
Street No. ———
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: RUDOLPH HAWKINS

3.(b) Social Security Number: ******

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ———
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): ——— 1872

8. AGE: Years 74 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: ———

FATHER
12. Name: ———
13. Birthplace: ———

MOTHER
14. Maiden name: ———
15. Birthplace: ———

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. ——— Date thereof ——— (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory ———
Location ———

18. Funeral director ———
Address ———

19. Dec 12 1946 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1946 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1912 to Dec. 4 1946 and that I last saw him alive on December 4 1946

Immediate cause of death	DURATION
General arteriosclerosis	known to us since 6/8/12
Due to	
Due to	
Other conditions: Senile phychosis known to us since 6/8/12	

(Include pregnancy within 3 months of death)

Major findings of operations: ***———
——— Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Albert J. Middendorf, M. D. or other
Address: Crownsville, Maryland Date signed: 12/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11728

CERTIFICATE OF DEATH

Reg. Dist. No. 280

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 7 days
Hospital, institution, or street address where death occurred:
State Hospital Crownsville, Md.
How long in hospital or institution? 3 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 North Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Roland Haywood

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married

6.(b) Name of husband or wife: Mrs. Ethel Haywood
27 North Eden Street, Balto. Md. 2
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years	Months	Days	If less than one day
57	-	-	- hrs. - min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: -

FATHER
12. Name: William Haywood
13. Birthplace: Maryland

MOTHER
14. Maiden name: Georgia V. Pierce
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary cem.
Location: Anne Arundel County
18. Funeral director: Byron & Mamie Wright
Address: 721 Argyle Ave. Balto.

19. 12/30 1946 E. T. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28th 1946 at 9 00 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 21st 1946 to December 28 1946
and that I last saw him alive on December 28th 1946

Immediate cause of death: General paresis

Due to: -

Due to: -

Other conditions: -

(Include pregnancy within 3 months of death)

DURATION: known to me since Septbr 21- 1946

Major findings of operations: -

Date of op. -

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?) -
Means of injury: - Injured at work? no

23. SIGNATURE: Ethel V. Haywood M. D. or other
Address: Crownsville, Md Date signed 12/28/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

★ 11720 Reg. Diat. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie. Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years.

Hospital, institution, or street address where death occurred: 104 Central Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Central Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice ELEANOR ~~Elizabeth~~ Hoffman.

3.(b) Social Security Number Non

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Christian F. Hoffman.

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Oct 24. 1888.

8. AGE: Years	Months	Days	If less than one day
58	1	19	....hrs. ....min.

9. Birthplace: A. A Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER — 12. Name: William Remmy.

FATHER — 13. Birthplace: A. A Co. Md

MOTHER — 14. Maiden name: Theresa Chaney.

MOTHER — 15. Birthplace: A. A Co. Md.

16. Informant: Christian F. Hoffman.

Address: Glen Burnie. Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 12/16/46 (month) (day) (year)

Cemetery or crematory: Glen Haven Cmt.

Location: Glen Burnie. Md

18. Funeral director: Wm. Tilghman & Sons Inc.

Address: Baltimore. Md

19. Dec 14 1946 (Date rec'd by registrar) A. W. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1946, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946, to Dec 13 1946, and that I last saw h...alive on Dec. 12 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Cardio-Vascular Disease.	10 years
Due to: Diabetes.	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: James S. Bellinger MD M. D. or other

Address: Glen Burnie. Md Date signed: Dec. 13, 1946

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

11730 8

CERTIFICATE OF DEATH pc

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 6 da.

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 4 yrs. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1342 Division St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: EMMA HOLMES

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ********

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): March 23, 1993

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	---	----		

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: domestic

11. Industry or business: ---

FATHER 12. Name: Steven Holmes

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Hanna Rone

MOTHER 15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof Dec. 9, 1946 (month) (day) (year)

Cemetery or crematory: Arbutus

Location: Baltimore County

18. Funeral director: J. P. Linbery

Address: 519 Mosher St., Balto., 17, Md.

19. 12-9 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 19 46 at 3:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 30 19 42, to Dec. 6 19 46 and that I last saw her alive on December 5 19 46

Immediate cause of death: hypertensive cardiovascular disease known to us since 11/30/42 — DURATION

Due to:

Due to:

Other conditions: Senile Psychosis known to us since 11/30/42

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 12/6/46

STATE OF MARYLAND—CERTIFICATE OF DEATH 1731

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County C. C. Registration Dist. No. 21

Village or City Manhattan Beach ND. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John Kara

(a) Residence: No. Manhattan Beach St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced. HUSBAND of (or) WIFE of Carolina Kara

6. DATE OF BIRTH (month, day, and year) Aug 19, 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	9	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Machinist

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Air Plane Factory

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Bohemia (State or country)

FATHER

13. NAME Joseph Kara

14. BIRTHPLACE (city or town) Bohemia (State or country)

MOTHER

15. MAIDEN NAME Not Known

16. BIRTHPLACE (city or town) Bohemia (State or country)

17. INFORMANT Caroline Kara (Address) Manhattan Beach

18. BURIAL, CREMATION, OR REMOVAL Place Cedar Hill Date Dec 23 46

19. UNDERTAKER Frank Brachden (Address) 900 Fulton St

20. FILED 12/23, 19 46 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec 20 1946 (Month) (Dey) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1946, to Dec 20, 1946

I last saw h. im alive on Dec 19, 1946; death is said to have occurred on the date stated above, at 7:15 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage, left	12/19/46
Other Contributory Causes of importance: Hypertensive Cardio-Vascular Disease with arteriosclerosis	1938

Name of operation — Date of —

What test confirmed diagnosis? Symptoms Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John P. Unluck Jr M. D.

(Address) 1227 Wash. Blvd.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

11732

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

Reg. Diat. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Winchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Winchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edgar J. Kemp.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Geneva Hall Kemp.
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feby 10th 1885

8. AGE:

Years	Months	Days	If less than one day
61	9	22	____ hrs. ____ min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: Clarence M. Kemp
13. Birthplace: Maryland
MOTHER 14. Maiden name: Alice Roby
15. Birthplace: Maryland
16. Informant: Jean Kemp McDonald
Address: c/o Mrs E. J. Kemp. Rt 2 Annapolis
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 11th 1946 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Baltimore, Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Dec 11, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8th 1946, at 11 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 15 1946, to Dec 8 1946
and that I last saw h... alive on Dec 8 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	30 minutes
Due to: Coronary Sclerosis	Several months
Due to:	
Other conditions: Hypertension	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury • Injured at work?

23. SIGNATURE: Edgar C Bond M. D. or other
Address: Annapolis Md. Date signed 12-10-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH (8C)

11733

Reg. Dist. No. 260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo. - 22 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 3 mo. - 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: ---------
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1903 Sapp St
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LOGAN - WALTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Widower

6.(b) Name of husband or wife: -------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1876 ?

8. AGE: Years: 70 | Months: ---- | Days: ---- | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: ---------

11. Industry or business

FATHER
12. Name: ---------
13. Birthplace ---------

MOTHER
14. Maiden name: ---------
15. Birthplace ---------

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof DEC. 28, 1946 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location: AA County Md.

18. Funeral director: Langrall & Sanders

Address: 1412 E. Preston St.

19. Dec 26 1946 (Date rec'd by registrar) A. M. Hedrick Registrar

1-25

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24, 1946 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22, 1946 to December 24 1946 and that I last saw him alive on December 24, 1946

Immediate cause of death: Cerebral Arteriosclerosis — DURATION: Known to us since 8/22/46

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Albert V. Whitehead M. D. or other

Address: Crownsville, Maryland Date signed 12/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

11734

Reg. Dist. No. 230

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore ~~City~~ County
City or town Baltimore 22
(If outside city or town limits, write RURAL and give nearest town)
Street No. 123 East Cherry Lane
(If rural, give LOCATION)
2.(a) If veteran, name war ---

3.(a) FULL NAME: PERCY LONESOME

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Grace Lonesome
6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years 60 | Months --- | Days ---- | If less than one day ... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: truckdriver

11. Industry or business ---

FATHER
12. Name ---
13. Birthplace Virginia

MOTHER
14. Maiden name Catherine Washington
15. Birthplace Virginia

16. Informant: Hospital Records
Address

17. buried (Burial, cremation, or removal. Which?) Date thereof Dec. 8, 1946 (month) (day) (year)
Cemetery or crematory Mount Zion
Location Baltimore County

18. Funeral director Joseph A. Lively
Address 661 W. Barre St. Baltimore, Maryland

19. Dec 7 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 19 46 at 12:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 19 46 to Dec. 4 19 46 and that I last saw h... im ...alive on December 3 19 46

Immediate cause of death	DURATION
General Arteriosclerosis	
known to us since 11/20/46	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---
--- Date of op. ---
Autopsy results ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury pppp--- Injured at work? ---

23. SIGNATURE [signature] M. D. or other
Address Crownsville, Maryland Date signed 12/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-2)

CERTIFICATE OF DEATH

11735

Reg. Diat. No.....

1. PLACE OF DEATH:
County Anne Arundel
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Greenway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rose Halsey Lord Lord

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife –
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 21, 1869

8. AGE: Years 77 | Months 8 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Brooklyn (Town, county, and state) New York

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Henry Edward Lord
13. Birthplace New York

MOTHER 14. Maiden name Mary Alice Hughes
15. Birthplace Nashville, Tenn

16. Informant MR. NELSON J. MOLTER
Address SEVERNA PARK, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 27, 1946 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Baltimore, Md

18. Funeral director WM. J. Tickner & SONS
Address BALTO., MD.

19. Dec. 27 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1946, at 7:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1946, to Dec 25 1946 and that I last saw her alive on Dec. 23 1946

Immediate cause of death	DURATION
arteriosclerotic - cardio - vascular renal disease	20 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Bowsuck M D
M. D. or other
Address Annapolis Md Date signed 12/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

P

11736

Reg. Dist. No. 220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Jessup

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Emma Elizabeth Fowlkamp

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Harry Fowlkamp

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 2 1870

8. AGE:

Years	Months	Days	If less than one day
76	10	16	hrs. min.

9. Birthplace: Baltimore City

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: Daniel Webster Janowitz

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary Meyers

15. Birthplace: Unknown

16. Informant: Mrs. J. Webster Fowlkamp

Address: Jessup Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/21/46 (month) (day) (year)

Cemetery or crematory: St. Laurence Cemetery

Location: Jessup Md.

18. Funeral director: WM. J. TICKNER & SONS, INC.

Address: North & Pa Aves. Balto. 17, Md.

19. 12-20 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18 1946, at 9 30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mch 1941, to Dec 18 1946

and that I last saw h alive on Dec 18 1946

	DURATION
Immediate cause of death: Chronic Nephritis (Kidney Disease)	4 yrs
Due to: Chronic Myocarditis	4 yrs
Due to: Senile Debility	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkridge Md. Date signed 12/19/46

12575

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

84b

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester County

City or town: Rural, Stockton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MANUEL - WALTER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	?

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years: 52 | Months: — | Days: — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER
12. Name: ?
13. Birthplace

MOTHER
14. Maiden name: ?
15. Birthplace

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial — Date thereof: Jan. 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Stockton Cemetery
Location: Stockton, Md.

18. Funeral director: H. Harvey Bradshaw
Address: Crisfield, Maryland

19. 1/3/47 19 Agatha E. Franklin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1946 at 11:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22, 1946, to December 31, 1946 and that I last saw him alive on December 31, 1946

Immediate cause of death: Schizophrenia (Catatonic Excitement) — DURATION: Known since admission Dec 22, 46

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert V. Ingerson M. D. or other

Address: Crownsville, Maryland Date signed: 12/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

12589

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

CERTIFICATE OF DEATH

Reg. Dist. No. 2 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County A. A.
City or town Jessups (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One week
Hospital, institution, or street address where death occurred: Mr. Wm. Simpson's farm
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town District Heights (If outside city or town limits, write RURAL and give nearest town)
Street No. 400 Avenue B (If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME Sam McGlone (SAMUEL ROSCOE McGLONE

3.(b) Social Security Number

4. Sex M
5. Color or race W.
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 33 Months 2 Days — If less than one day ... hrs. ... min.

9. Birthplace Cincinnati Ohio (Town, county, and state)
10. Usual occupation Seamen
11. Industry or business Merchant Marine

FATHER
12. Name Samuel M. McGlone
13. Birthplace Ky

MOTHER
14. Maiden name Mary Ellen Townsend
15. Birthplace Ky

16. Informant Mrs Roger De Ville
Address 400 Avenue B. District Heights, Md

17. ~~Burial~~ Cremation Date thereof Dec 24 '46 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland Rd SE, Wash. D. C.

18. Funeral director Lloyd Kaiser Inc.
Address 381 Main Street, Laurel, Maryland

19. Dec 24 1946 (Date rec'd by registrar) Clara Hasluf Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1946, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death Accidental burns — DURATION Five minutes
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 12/22/46
Where did injury occur? Jessups (City or town) A. A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fire Injured at work? No

23. SIGNATURE Gustave H. Pancherkiw [?] M. D. or other
Acting medical examiner
Address Glen Burnie Md Date signed 12/22/46

VS A15

2-35

JJ

12576

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:
Dispensary "A", Fort George G. Meade, Md.

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Aberdeen Proving Ground (U.S.Army)
(If outside city or town limits, write RURAL and give nearest town)

Street No. 613 Base Unit, c/o M/Sgt. Billy G. Mc Lelland
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: BABY BOY McLELLAND

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife: -

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 25 December 1946

8. AGE: Years	Months	Days	If less than one day
-	-	-	4 hrs. ____ min.

9. Birthplace: Fort George G. Meade, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: -

FATHER
12. Name: M/Sgt Billy G. McLelland
13. Birthplace: Waco, Texas

MOTHER
14. Maiden name: Mary Jo Leitch
15. Birthplace: Stone Mountain, Georgia

16. Informant: Medical Records, Station Hospital
Address: Fort George G. Meade, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/46 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Fort George G. Meade, Md.

18. Funeral director: Howard H. Blight Jr.

Address: 4914 Belair Road, Baltimore 6, Md.

19. 26 December 1946 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., Registrar

PC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 December 1946, at 1300 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 25 December 1946 to 25 December 1946 and that I last saw him alive on 25 December 1946

Immediate cause of death	DURATION
Prematurity	
6 months gestation	
Due to: Unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lowell F. Peterson M.D.
Capt. M.C.
M. D. or other

Address: Ft. Geo. Meade Md. Date signed 8 Jan 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

CERTIFICATE OF DEATH

11737

Reg. Dist. No. 27-0

1. PLACE OF DEATH:

County Anne Arundel

City or town Fort George G. Meade, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Station Hospital, Fort Geo. G. Meade, Md.

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. CO.

City or town Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No. Thompson Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American Retired soldier World I

3.(a) FULL NAME WILLIAM JOSEPH MEKINS

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Virginia Agnes Mekins

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) - February 18, 1870

8. AGE: Years	Months	Days	If less than one day
76	10	2	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Retired Soldier

11. Industry or business

FATHER 12. Name Joshua Mekins

13. Birthplace Del. Dorchester Co. Md.

MOTHER 14. Maiden name Zizia, Smith

15. Birthplace MD.

16. Informant Mr. Elmer J. Mekins

Address 15 Summit Ave., Baldwin, N. Y

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/23/46 (month) (day) (year)

Cemetery or crematory Balto. Nat'l Cem.

Location Baltimore Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa Aves. Balto. 18, Md.

19. 20 Dec. 1946 (Date rec'd by registrar) BERNARD F. KESSLING, Capt, MC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 December 1946, at 0024 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Dec 1946, to 20 Dec 1946 and that I last saw him alive on 2100 19 Dec 1946

Immediate cause of death	DURATION
Uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Jr Capt MC M. D. or other

Address Reg. Hospital N. Meade Date signed 30 Dec 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-f)

CERTIFICATE OF DEATH

Reg. Dist. No. 11738 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: G. A. Co.

City or town: Glenburnie (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: G. A. Co.

City or town: Glenburnie (If outside city or town limits, write RURAL and give nearest town)

Street No.: Quarterfield Road. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William A. Meyers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 12 1889

8. AGE: Years: 57 Months: 5 Days: 20 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Plumber Helper

11. Industry or business

FATHER — 12. Name: Herman C. Meyers

FATHER — 13. Birthplace: Phila. Pa.

MOTHER — 14. Maiden name: Anna Wagner

MOTHER — 15. Birthplace:

16. Informant: Elizabeth A. Scherer

Address: Glenburnie Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-5-1946 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: G. A. Co. Md.

18. Funeral director: Flynn & Flynn

Address: 1412 Light St.

19. 12-4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5 1946, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1946, to Dec. 3 1946 and that I last saw h... alive on Dec. 5 1946

Immediate cause of death	DURATION
Cancer of Mediastinum	6 mo.
Due to	
Due to	
Other conditions Stricture of oesophagus (Pressure)	3 mo.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas. L. Ball J. M.D. M. D. or other

Address: Linthicum Date signed 12-3-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

(BC)

11739

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since December 8-46

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? Since December 8-46

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1104 Carrollton AVE (If rural, give LOCATION)

2.(a) If veteran, name war: World War No. I.

3.(a) FULL NAME: Richard H. Mooney

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	married

6.(b) Name of husband or wife: Willie Louise Mooney

6.(c) If alive, give age: 2 years

7. Birth date of deceased (mo., day, yr.): Maryland XII-22-92

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	11	15	/	/

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: furniture mover

11. Industry or business: /

FATHER — 12. Name: Daniel Mooney

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie Mooney

MOTHER — 15. Birthplace: Maryland

16. Informant: Wife; Annie Mooney

Address: 1104 Carrollton Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-18-46 (month) (day) (year)

Cemetery or crematory: Balto. National

Location: Balto. City

18. Funeral director: Saml. W. Ekase & Son

Address: 638 N. Gilmor St

19. 12-17 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15th 19 46 at 8 20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8th 19 46 to December 15 19 46 and that I last saw him alive on December 14th 19 46

Immediate cause of death: cerebral hemorrhage — DURATION: One day

Due to: cardio-renal disease — DURATION: under treatment since December 8-1946

Due to:

Other conditions: Psychosis With cardio-renal disease

(Include pregnancy within 3 months of death)

Major findings of operations: no — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: no — Injured at work? no

23. SIGNATURE: Albert V. Whitehead M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11740

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Parole Md near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
2 First St. Parole Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2 First Street Parole Md.
(If rural, give LOCATION)
****
2.(a) If veteran, name war:

3. (a) FULL NAME: Lemenia Moore

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., dsy, yr.): Febuary 18, 1861

8. AGE: Years: 85 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: West River Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation: Dress Maker

11. Industry or businss: None

FATHER
12. Name: Henry Offer
13. Birthplace: West River Anne Arundel Co. Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Georgianna Simms
Address: 2 First St. Parole Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 12- 8- 1946
(month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Annapolis Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. 12-8-46 19
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 19 46 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 19 46 to Dec 4, 19 46 and that I last saw h alive on Dec 4, 19 46

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to Arterial Hypertension	2 yrs
Due to	
Other conditions Arterio-Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. C. Richardson M.D.
M. D. or other
Address: Annapolis Md. Date signed Dec 7, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1225)

CERTIFICATE OF DEATH

11741

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred: Emergency Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis or Shadyside
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward J. Mudd. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Gertrude V. Casey
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 27 - 1872

8. AGE: Years	Months	Days	If less than one day
74	4	24	hrs. min.

9. Birthplace: Charles Co. Md. (Town, county, and state)
10. Usual occupation: Retired Policeman
11. Industry or business:
FATHER 12. Name: Samuel A. Mudd
13. Birthplace: unknown
MOTHER 14. Maiden name: "
15. Birthplace: "
16. Informant: Hosp. Records
Address
17. Burial (Burial, cremation, or removal, Which?) Date thereof 12-27-46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington, D.C.
18. Funeral director: Petrie Bros.
Address: Upper Marlboro, Md.
19. Dec 22 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 19 46 at 1 52 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to Dec. 22 19 46
and that I last saw h.. alive on Dec 22 19 46

Immediate cause of death	DURATION
bronchopneumonia	5 days
intestinal Obstruction	10 days
Due to: Incarcerated hernia	3 mos (?)
Due to:	
Other conditions: Arteriosclerosis cardiovascular disease	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Int. Obstruction due to incarcerated hernia Date of op. 12/17/46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Bernstein M.D.
M. D., or other
Address: Annapolis Md. Date signed 12/22/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

★ 11742

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ferndale Md. (Brooklyn RFD #9)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Three Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Ferndale, Md. Brooklyn RFD #9
(If outside city or town limits, write RURAL and give nearest town)

Street No. 512 Old Annapolis Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry D. Mueller

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mina C. Mueller

nee EITEL 6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): December 8, 1867

8. AGE: Years	Months	Days	If less than one day
79	0	12	....hrs. ....min.

9. Birthplace: Altebelzen, Hanover, Germany
(Town, county, and state)

10. Usual occupation: Farmer (retired)

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: Mrs. Mina C. Mueller

Address: Ferndale, Brooklyn, RFD # 9. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 23 46 (month) (day) (year)

Cemetery or crematory: St. Pauls Lutheren Church

Location: Charlotte Hall

18. Funeral director: Thomas W. Singleton (F.D.)

Address: Glen Burnie, Md.

19. Dec. 23 19 46 (Date rec'd by registrar) McCall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 19 46 at 4.05 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August - 10 1940 to December 20 1946

and that I last saw h[er] alive on 12/20/46 19....

Immediate cause of death	DURATION
Lobar pneumonia	8 days
Due to: Generalized arteriosclerosis	2
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?)

Means of injury: ....Injured at work?

23. SIGNATURE: Gustave K. Rauchenbusch M. D. or other

Address: Glen Burnie, Md. Date signed: 12/21/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

11743

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21 2

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(Ext. newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills, P.O.,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cram Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Kenton Lewis Mullenax

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ollie A. Mullenax
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec. 10, ~~1876~~ 1865

8. AGE:

Years	Months	Days	If less than one day
80	11	25	...hrs. ...min.

9. Birthplace: Monterey, Virginia
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: general farming
FATHER
12. Name: Henry Mullenax
13. Birthplace: Circleville, W. Va.
MOTHER
14. Maiden name: Elizabeth Calhoun
15. Birthplace: Dog Run, W. Va.
16. Informant: Mrs. John Hevener
Address: Gambrills Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 7 1946 (month) (day) (year)
Cemetery or crematory: Baldwin Memorial
Location: Seven Cross Roads, Millersville, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md
19. Dec 6 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 4 1946, at 8 45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2 1946, to Dec. 4 1946
and that I last saw h. I M. alive on Dec. 4, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Arterio-sclerosis	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: John M. Clatty M.D.
M. D. or other
Address: Annapolis, Md Date signed 12-5-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

★ 11744

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: A. A.

County

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred: Severna Park

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A.

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. Severna Park (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lenora Myers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	widow

6.(b) Name of husband or wife: Alfred Elijah Myers

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2 1872

8. AGE: Years	Months	Days	If less than one day
74	9	24	hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Elijah Grinnage

13. Birthplace Md

MOTHER 14. Maiden name Charity Boone

15. Birthplace Md

16. Informant Dedonia Pack

Address Severna Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29 46 (month) (day) (year)

Cemetery or crematory Townsend

Location Severna Park

18. Funeral director J. B. Johnson

Address Annapolis

19. Dec. 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 19 46 at 5.30 A M

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased from~~ CORONERS-CASE to BODY VIEWED and that I last saw ~~him~~ alive on AT 9:30 A.M. 19

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Linhardt MD M.D. or other

Address 3 Chesapeake Ave., Eastport, Md Date signed 12/27/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

11745

Reg. Diat. No. 25

1. PLACE OF DEATH:
County: A. G.
City or town: Brooklyn Pk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
101 - 1st Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.H.
City or town: Brooklyn Pk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 1st Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Adelaide A. Yeats

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Louis H.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10/28/1904

8. AGE: Years: 42 | Months: 1 | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Kyemmel
13. Birthplace: Md ?

MOTHER
14. Maiden name: Jemmel ?
15. Birthplace: Md

16. Informant: Family

Address: 101 1st Ave.

17. (Burial, cremation, or removal. Which?) Date thereof: 12-10-46 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: Brooklyn

18. Funeral director: J. H. McCully

Address: 160 E. Pratt St.

19. Dec 9 1946 (Date rec'd by registrar) Ida M. Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/7 1946, at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1944, to Dec 7 1946
and that I last saw h... alive on ..... 19....

Immediate cause of death	DURATION
metastatic Carcinoma of Breast, Lft.	
Due to: Lobular type	
Due to	
Other conditions: arthritis very severe	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Samuel Rubin M.D.
M. D. or other
Address: 203 Polepsco Av. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(122a) (5) 1:746

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Defense Highway
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Virginia Nichols

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: J. Wilson Nichols

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 1, 1911

8. AGE: Years	Months	Days	If less than one day
35	8		..... hrs. ..... min.

9. Birthplace: Lynchburg Va
(Town, county, and state)

10. Usual occupation: .....

11. Industry or business: House wife

FATHER
12. Name: J. W. Mattie
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jennie Giles
15. Birthplace: Va.

16. Informant: J. Wilson Nichols
Address: Annapolis R.T.D. #2

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof Dec 24th 1946
(month) (day) (year)

Cemetery or crematory: St Margarets

Location: St Margarets 996 Md

18. Funeral director: Jacob M. Gaylor Son

Address: Annapolis Md.

19. Dec. 23 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 19 46, at 330 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 18 19 46, to Dec. 21 19 46
and that I last saw h.. alive on Dec. 21, 1946 19..

Immediate cause of death	DURATION
Cardio respiratory failure	
Due to: Acute dilatation of Stomach	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 1) Strangulated hernia
2) Internal hemorrhage Date of op. Dec 18 & 19 46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward P. Ritchings M.D.
M. D. or other

Address: 199 Prince Geo. St. Annapolis, Md. Date signed: Dec 21, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 11747

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Southgate Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Cathalina Viele Alyphant

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Talbat Alyphant
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1844

8. AGE: Years	Months	Days	If less than one day
102	5	18	..... hrs. ..... min.

9. Birthplace: Albany, N. Y.
(Town, county, and state)
10. Usual occupation:
11. Industry or business
FATHER — 12. Name: Ryphas King Viele
13. Birthplace: Albany, N. Y.
MOTHER — 14. Maiden name: Phebe Ann Gregory
15. Birthplace: Albany, N. Y.
16. Informant: Mrs. John de Peyster Dauw
Address: Southgate Ave.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 12-31-46 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Pri Geo Co Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.
19. Dec. 30 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 29 1946, at 10 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1946 to Dec 29th 1946 and that I last saw h[illegible] alive on Dec 29 1946

Immediate cause of death	DURATION
Cardio Vascular Failure	One Day
Due to: Senile Arteriosclerosis	Several Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Annapolis Md. Date signed: 12/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11748

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: A A.

City or town: Crownsville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Sept. 18, 1946

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md

How long in hospital or institution? Since Sept 18, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery Co

City or town: Cabin John, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Edward Palmer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife: Frances Palmer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 49 years abd 2. 1897

8. AGE: Years	Months	Days	If less than one day
49 2.	—	—	hrs. min.

9. Birthplace: unknown to us (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER — 12. Name: unknown to us

FATHER — 13. Birthplace

MOTHER — 14. Maiden name: unknown to us

MOTHER — 15. Birthplace

16. Informant: Hospital records

Address: State Hospital, Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-10-46 (month) (day) (year)

Cemetery or crematory: Wash D C

Location: Jarvis

18. Funeral director: W Ernest Jarvis Co

Address: 1932 you 20 NW Wash DC.

19. 12/8 1946 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1946 at 11 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18, 1946 to Dec. 7, 1946 and that I last saw h. alive on Dec. 7, 1946

	DURATION
Immediate cause of death:	
Due to: Gunshot Wounds	Known to us since Sept 18, 46
Due to: Syphilis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Albert V. Hinkwood M. D. or other

Address: Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 11749201

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Owensville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Owensville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) none
2.(a) If veteran, name war

3. (a) FULL NAME: Wilem Parker

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Widowed

6.(b) Name of husband or wife: Louise Barnt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1886

8. AGE: Years	Months	Days	If less than one day
59	11	24	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Farm hand
11. Industry or business: Agriculture
FATHER 12. Name: John Parker
13. Birthplace: Drury A. A. Co Md
MOTHER 14. Maiden name: Sophia Aringt
15. Birthplace: Md
16. Informant: Maria Parker
Address: Owensville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12, 1946 (month) (day) (year)
Cemetery or crematory: Moses Adams Chapel
Location: Drury, Md
18. Funeral director: T.A. Hardesty & Son
Address: Galesville, Md.
19. 12/12 1946 (Date rec'd by registrar) M. M. Clayton Dep. Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1946 at 10 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 7 1946 to Dec. 9 1946 and that I last saw h. alive on Dec. 9 1946

Immediate cause of death	DURATION
coronary thrombosis (?)	
Due to: arteriosclerosis -	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily A. Wilem, M.D.
M. D. or other
Address: Lothian, Md. Date signed: 12/10/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

2- 200 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

D1750

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 29 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 8 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 423 North Fremont Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: MANTON PENDERGAST

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Mrs. Annie Pendergast

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): October 8, 1901

8. AGE: Years	Months	Days	If less than one day
45	1	3	....hrs. ....min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -----

FATHER — 12. Name: Cisar Pendergast

13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Della Gillmore

15. Birthplace: South Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 15, 1946 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial Park

Location: Arbutus, Maryland

18. Funeral director: Miss Kate R. Williams

Address: 322 N. Schroeder St., Balto., Md.

19. 12/17/46 (Date rec'd by registrar) A. W. Bedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 19 46 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13 19 46 to Dec. 11 19 46

and that I last saw him alive, on Dec. 11 19 46

	DURATION
Immediate cause of death: Lung tuberculosis known to us since	10/23/46
Due to:	
Due to:	
Other conditions: Schizophrenia known to us since 2/13/46	

(Include pregnancy within 3 months of death)

Major findings of operation: -------

---- Date of op. ---

Autopsy results: --------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: -----

Where did injury occur? 0000 (City or town) ------- (County) (State)

Injured at home, farm, industry, public place (where?): --------

Means of injury: ----- Injured at work? ---

23. SIGNATURE: Robert P. Windsor M. D. or other

Address: Crownsville, Maryland Date signed: 12/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

11751 280

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo. - 9 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 mo. - 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 718 Wilmer Court
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

PRICE - LEE (Le Roy Price)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	?

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
67 plus	---	---	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: ———

11. Industry or business

FATHER 12. Name: George Price

13. Birthplace: ———

MOTHER 14. Maiden name: ———

15. Birthplace

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-3-47 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Balto, Maryland

18. Funeral director: William A. Jackson

Address: 916 Penna. Ave, Balto,

19. 1-2 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 19 46 at 9:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23, 19 46, to December 31, 19 46 and that I last saw him alive on December 31, 19 46

Immediate cause of death: General Arteriosclerosis — DURATION: Known since admission Oct 23, 46

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert J. Pinkard Jr. M. D. or other

Address: Crownsville, Maryland Date signed: 12/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-E)

CERTIFICATE OF DEATH

11752

Reg. Diat. No. 280

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 2 mo., 3 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 3 yrs., 2 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Port Tobacco
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ------
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME

CORA PROCTOR

3. (b) Social Security Number

------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): unknown to us

8. AGE: Years	Months	Days	If less than one day
38 ?	--	---	...hrs. ...min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: none

11. Industry or business: -----

FATHER
12. Name: John Proctor
13. Birthplace: Charles County, Maryland

MOTHER
14. Maiden name: Virgin Thompsom
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/46 (month) (day) (year)

Cemetery or crematory: St. Thomas

Location: Bel Alton, Md

18. Funeral director: Hunt & Ryan

Address: Hyattsville, Md.

19. 12-18-46 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 19 46 at 1:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 43 to Dec. 18 19 46 and that I last saw her alive on Dec. 17 19 46

Immediate cause of death	DURATION
lung tuberculosis	known to us since 10/15/43
Due to	
Due to	
Other conditions: Feeblemindedness known to us	since 10/15/43

(Include pregnancy within 3 months of death)

Major findings of operation: ------

Date of op.: ---

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: ---- Injured at work? ---

23. SIGNATURE: Albert L. Winfrock M. D. or other

Address: Crownsville, Maryland Date signed: 12/18/46

VS (AH) 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if possible. Physicians: please write the causes of death clearly and legibly. This is especially important.

1-35

11753 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A.A.
City or town Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State Md County A.A.
City or town Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural give LOCATION)
2.(a) If veteran, name war Spanish American

3. (a) FULL NAME William B. Pruett

3. (b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced M
6.(b) Name of husband or wife Lena Meyer
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan. 18, 1876
8. AGE: Years 70 Months 11 Days 2 If less than one day ... hrs. ... min.
9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Family
Address Orchard Beach
17. B. Date thereof 12-23-46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Meadowridge Cem.
Location Dorsey Md
18. Funeral director James L. McCully
Address 130 E. Fort Ave
19. 12/21/46 (Date rec'd by registrar) 19 ... O. Alvo Hedrick Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1946, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1946, to Dec. 20 1946 and that I last saw him alive on December 15 1946

	DURATION
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE J. Brady Smith M. D. or other
Address Riviera Beach, Md. Date signed 12/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

11754

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: a a

City or town: Eastport Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 1/2 Years

Hospital, Institution, or street address where death occurred: Bay Ridge Road.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Eastport Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bay Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward J. Rawlings Sr

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Georgie May Rawlings

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 24 — 1882

8. AGE:

Years	Months	Days	If less than one day
64	7	10	...hrs. ...min.

9. Birthplace: a a Co md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: William J Rawlings

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie E Seible

MOTHER — 15. Birthplace: Maryland

16. Informant: Georgie May Rawlings

Address: Bay Ridge Road Eastport

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 7/46 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial

Location: Glen Burnie Md

18. Funeral director: C. L. Hopping & Son

Address: Annapolis Md

19. Dec 7, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 4 19 46, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 46, to Dec 4 19 46

and that I last saw him alive on Dec 4 19 46

Immediate cause of death	DURATION
Carcinoma Stomach	Several Months
Due to	
Due to	
Other conditions: Cerebral Edema Moderate	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo C Beal M. D. or other

Address: Annapolis md Date signed: 12-6-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Dist. No. 11755

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1019 Leadenhall Street (If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: MARGARET READ

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	separated

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years	Months	Days	If less than one day
53	--	--	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ---

FATHER
12. Name: Howard Bailey
13. Birthplace: Virginia

MOTHER
14. Maiden name: Hister Dix
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 20, 1946 (month) (day) (year)
Cemetery or crematory: Mount Cavalry
Location: Anne Arundel County
18. Funeral director: Walter B. Spriggs
Address: 139 Hamburg St., Balto., Md.

19. 12-17 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 19 46 at 10:45a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 46 to Dec. 16 19 46 and that I last saw her alive on December 16 19 46

Immediate cause of death: General arteriosclerosis — DURATION: known to us since 7/15/46

Due to: ---

Due to: ---

Other conditions: psychosis with cerebral arteriosclerosis known to us since 7/15/46
(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 12/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11756 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

BC Reg. Dist. No. 58

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 2 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1129 North Stricker St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: ELLA REEDER

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years
7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
70 ?	—	—	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: ———

FATHER
12. Name: William Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Thomas
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1946 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Baltimore City

18. Funeral director: Mrs. Ida Bailey
Address: 1421 Jefferson St., Balto., Md.

19. 12/13 1946 (Date rec'd by registrar) A. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 19 46, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9 19 46, to Dec. 11 19 46
and that I last saw her alive on Dec. 10 19 46

Immediate cause of death	DURATION
General arteriosclerosis	known to us since 9/9/46
Due to	
Due to	
Other conditions: Senile Psychosis	known to us since 9/9/46

(Include pregnancy within 3 months of death)

Major findings of operation: ———
Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Herbert T. Woodward M. D. or other
Address: Crownsville, Maryland Date signed: Dec. 11

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (140-c)

Registered No. 11757

Evidence for the change of date of death is shown on G 108, 1/6/47

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland
(b) Street address Anne Arundel Glenburnie - Md.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glenburnie Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY Ross

3 (b) If veteran, name war	3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1/1923

8. AGE: Years	Months	Days	If less than one day
23	5	~~18~~ 17	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Montgomery Ward

FATHER
12. Name Herschell Ross
13. Birthplace Md

MOTHER
14. Maiden Name May Simmons
15. Birthplace Md

16 (a) Informant Hershell Ross
(b) Address 1116 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. Wolfe St.

19 (a) 12/20/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH December 19, 1946 at 2 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Infected abortion, probably self-induced.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/19/46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

11758

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ANNE ARUNDEL Co.
City or town: PASADENA, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: ANNE ARUNDEL
City or town: PASADENA, MD
(If outside city or town limits, write RURAL and give nearest town)
Street No.: MT. ROAD NEAR LIPTON'S CORNER
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: WILLIAM CLEVELAND SHARP, SR.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: ANNA SHARP (HAHN)
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): AUG 29, 1884

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace: ANNE ARUNDEL Co. (Town, county, and state)
10. Usual occupation: GRADER OPERATOR
11. Industry or business

FATHER
12. Name: JOHN SHARP
13. Birthplace: ANNE ARUNDEL Co.

MOTHER
14. Maiden name: MARY M. SAPINGTON
15. Birthplace: ANNE ARUNDEL Co.

16. Informant: MRS DOROTHY KINDER
Address: PASADENA, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12/30/46 (month) (day) (year)
Cemetery or crematory: MEADOWRIDGE
Location: WASHINGTON BLVD.

18. Funeral director: JOHN F. DENNY, INC.
Address: 715 LIGHT ST.

19. Dec 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 19 46 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 26 19 46, to 19
and that I last saw him alive on Dec 24th 19 46

Immediate cause of death: Cerebral hemorrhage — DURATION: 1 hour

Due to: Arterio Sclerosis — DURATION: long time

Due to: Chronic Interstitial Nephritis — DURATION: long time

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Alexander M. D. or other
Address: Glen Burnie Md. Date signed 12/28/46

Dr. Alexander

Dr. Alexander
Gen Comic

Mrs Dietlin

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

11759

★ Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Weems Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Weems Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Leo Sindall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Gertrude Ward Sindall
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 3rd 1886

8. AGE: Years	Months	Days	If less than one day
60	9	19	____ hrs. ____ min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Coffee Broker
11. Industry or business:
MOTHER FATHER 12. Name: James W. Sindall
13. Birthplace: Baltimore Md.
MOTHER 14. Maiden name: Mary B. Smuck
15. Birthplace: Baltimore Md.
16. Informant: Mrs. J. Leo Sindall
Address: Weems Creek Q A C Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 26th 1946 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Baltimore Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. Dec 25, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 1946, at 3350 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1946, to Dec 22 1946
and that I last saw him alive on Dec 22 1946

Immediate cause of death	DURATION
Coronary Occlusion	5 hrs
Due to: Cardio Vascular	
Due to: Failure	Sudden
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Oliver Parran M. D. or other
Address: Annapolis Md. Date signed 12/22/46

1-35

11760

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 54 Washington Street
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 54 Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alexander Sisco

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 14, 1870

8. AGE: Years	Months	Days	If less than one day
76	1	26	hrs. min.

9. Birthplace: Annapolis Maryland (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business: Barber

FATHER
12. Name: Alexander Sisco Sr.
13. Birthplace: Annapolis Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Annapolis Maryland

16. Informant: Fannie Queen
Address: 54 Washington Street

17. (Burial, cremation, or removal. Which?) Burial
Date thereof: 12--13--1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. (Date rec'd by registrar) 12/14/46 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10, 1946, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6, 1946, to Dec. 10, 1946
and that I last saw h.i.m. alive on December 10, 1946

Immediate cause of death	DURATION
Cardiac failure	2 days
Due to Hypertensive Cardio-Vascular Disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Theodore H. Johnson M. D. M. D. or other
Address: 40 Northwest Street Date signed: 12/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

12590

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:
County Anne Arundel
City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest towo)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Station Hospital, Fort George G. Meade, Md.
How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest towo)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LEONARD L. SMITH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
27			hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation Soldier (Tec 4, RA 15 012 371)
11. Industry or business Regular Army
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden name
15. Birthplace
16. Informant
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof 26 Dec. 1946 (month) (day) (year)
Cemetery or crematory Walter Bauknecht Funeral Home
Location Bellaire, Ohio
18. Funeral director Howard N. Blight, Jr. Howard N. Blight Jr.
Address 4914 Belair Road, Baltimore 6, Maryland
19. 26 December 1946 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., Registrar Bernard F. Kerwin
PC

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 December 1946 at 10:50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24 1946 to Dec 24 1946
and that I last saw him alive on Dec. 24 1946

	DURATION
Immediate cause of death: Sub-dural hematoma	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation NONE Date of op.
Autopsy results Sub-dural hematoma
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wellington B. Stewart MD
M. D. or other
Address Sta Hosp, Ft Geo G Meade, Md. Date signed 26 Dec 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54a)

CERTIFICATE OF DEATH

Reg. Dist. No. 20 11361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

1. PLACE OF DEATH:
County Anne Arundel.
City or town Fairhaven.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Anne Arundel
City or town Fairhaven - Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Chas. Jordan Spicknall.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife Mary Irene Spicknall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
54			..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation carpenter & farmer.
11. Industry or business

FATHER
12. Name Chas. J. Spicknall.
13. Birthplace Calvert County.

MOTHER
14. Maiden name Maria L. Krug.
15. Birthplace Calvert Co.

16. Informant Chas. Spicknall Jr.
Address Fairhaven.

17. Burial, cremation, or removal. Which? Buried — Date thereof 12/24/46 (month) (day) (year)
Cemetery or crematory Friendship. Md.
Location Friendship - Md.
18. Funeral director W. H. Hutchins
Address Owings - Calvert Co. Md.
19. 12/23 1946 (Date rec'd by registrar) W. H. Clayton. By [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1946 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1946, to Dec. 22 1946 and that I last saw him alive on Dec. 21 1946

Immediate cause of death	DURATION
Glyoma of brain	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emrich H. Wilson, M.D. M. D. or other
Address Lothian, Md. Date signed 12/23/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11762

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 518 Sixth Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Agnes Franklin Stevens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John B. Stevens
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 11th 1903

8. AGE: Years	Months	Days	If less than one day
43	8	26	hrs. min.

9. Birthplace: Calvert County, Maryland
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Amos Lee Hall
13. Birthplace: Calvert Co. Md.

MOTHER
14. Maiden name: Bettie Carroll
15. Birthplace: Calvert Co. Md.

16. Informant: John B. Stevens
Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1946 (month) (day) (year)
Cemetery or crematory: Edwards Chapel
Location: (none) Annapolis, Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis, Maryland

19. Dec. 9, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 1946, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1946, to Dec 6 1946
and that I last saw her alive on Dec 6 1946

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions: Acute Myocarditis	2 wks
Acute Nephritis	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo C Boul M. D. or other
Address: Annapolis Md Date signed: 12-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

54 Cornhill

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

11763

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1420 West
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cora Stevens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26th 1874

8. AGE:

Years	Months	Days	If less than one day
72	2	18	hrs. min.

9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name William F. Stevens
13. Birthplace Calvert Co Md

MOTHER
14. Maiden name Mary E. Hardesty
15. Birthplace Calvert Co Md

16. Informant Miss Norma Wood
Address 632 Washington Blvd. Balto Md.

17. Burial Date thereof Dec 16th 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Richie Highway A A Co Md

18. Funeral director John M. Taylor Son
Address Annapolis Md.

19. Dec 16 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec 1946 at 9 35 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 13 Dec 1946 to 13 Dec 1946 and that I last saw h.. alive on 13 Dec 1946

Immediate cause of death	DURATION
Coronary occlusion	1 hour
Cardiac failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Donald H. Hoskey, M. D.
M. D. or other
Address 53 Cornhill St Annapolis Md Date signed 13 Dec 46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

P 11764 46 230

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
County Wyndon Rd
City or town Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County 2
City or town Brooklyn Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No. 335 N. Water St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Katherene Fredericka Swartz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, (widowed), or divorced
fem	white	

6.(b) Name of husband or wife Harvey Swartz
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1872

8. AGE: Years 74 | Months 9 | Days 2 | If less than one day: hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Lewis C. Harle
13. Birthplace Germany

MOTHER 14. Maiden name
15. Birthplace Germany

16. Informant Virginia Mae Feezer
Address Linthicum Heights

17. Burial Date thereof 12-20-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill - Brooklyn
Location Brooklyn, Md.

18. Funeral director John A. Strohmaier
Address 423 S. Paca St.

19. 12-19-46 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 17 19 46 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-10 19 46 to 12-17 19 46 and that I last saw her alive on 12-16 19 46

Immediate cause of death	DURATION
Delayed Labor	
Ruptured uterus	
Failure	
Due to Extensive Uterine Hemorrhage	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. B. Summers M.D.
M. D. or other
Address 10 S. Kane Date signed 12-18-46

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 11765

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6yr., 9 mo., 27 da.

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 6 yr., 9 mo., 27 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltim ore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 815 Aisquith Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME: ADDIE TAYLOR

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: William Taylor (deceased)

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): June 4, 1904

8. AGE:

Years	Months	Days	If less than one day
42	6	8	... hrs. ... min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ———

FATHER
12. Name: ———
13. Birthplace: ———

MOTHER
14. Maiden name: ———
15. Birthplace: ———

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-20-46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.
Address: Crownsville Md

19. 12-20-46 (Date rec'd by registrar) 19 ... Effie Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 46, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 19 39, to Dec. 12 19 46 and that I last saw her alive on Dec. 11 19 46

Immediate cause of death	DURATION
Lung Tuberculosis known to us since	12/8/46
Due to	
Due to	
Other conditions: Schizophrenia Catatonic Type known to us since	2/15/39

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ———

Means of injury: ——— Injured at work? ———

23. SIGNATURE: Herbert V. Brietzke M. D. or other

Address: Crownsville, Maryland Date signed: 12/12/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 11762 2

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Anne Arundel

City or town Laurel R. F. D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Laurel R. F. D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Tisdale

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Mrs Tennon

6.(b) Name of husband or wife Mrs Tennon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mrs Tennon 1867

8. AGE: Years	Months	Days	If less than one day
about 79			..... hrs. ..... min.

9. Birthplace Canada
(Town, county, and state)

10. Usual occupation Farmer Wife

11. Industry or business R.F.

FATHER 12. Name Mrs Tennon

FATHER 13. Birthplace Mrs Tennon

MOTHER 14. Maiden name Mrs Tennon

MOTHER 15. Birthplace

16. Informant Mrs Hunt
Address Laurel

17. Burial Date thereof Dec 6 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ivy Hill

Location Laurel Md

18. Funeral director Ridgely Selby

Address 401 Wash ave Laurel Md

19. Dec 4 1946 Clara Eastlick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 - 1946, at 2 24 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Dec 2 1946

and that I last saw h— alive on Dec 2 1946

Immediate cause of death	DURATION
Hemiplegia	3
Due to Arteriosclerosis	
Due to Chronic Interstitial Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mrs Tennon M. D. or other

Address Laurel Date signed 12/4/46

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11767

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Harwood, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME Walter Tongue

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1925

8. AGE: Years	Months	Days	If less than one day
21	3	3	..... hrs. ..... min.

9. Birthplace: Harwood, A.A.Co., Md.
(Town, county, and state)

10. Usual occupation: Farm hand

11. Industry or business: Farm

FATHER
12. Name: Richard Tongue
13. Birthplace: Harwood. Md.

MOTHER
14. Maiden name: Hester Moulden
15. Birthplace: Lothian, Md.

16. Informant: Frank Tongue
Address: Shadyside, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 8 1946 (month) (day) (year)

Cemetery or crematory: Daniel Star
Location: West River, Md

18. Funeral director: T.A.Hardesty & Son
Address: Galesville, Md.

19. Dec. 6, 1946 (Date rec'd by registrar) W. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 19 46 at 10.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1946, to Dec. 1946

aed that I last saw h...m alive on Dec 4 19...

Immediate cause of death	DURATION
Pulmonary T. B.	
Due to Pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Emily H. [illegible] M. D. or other

Address Lothian. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15. 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-6)

CERTIFICATE OF DEATH

11768

Reg. Dist. No. 2/1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few minutes
Hospital, Institution, or street address where death occurred:
Dr. B. Smith's office
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel.
City or town: P.O. Pasadena.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mountain Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hallard Ernest Tydings

3.(b) Social Security Number: 219-01-7058

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14 - 1913

8. AGE:

Years	Months	Days	If less than one day
33	5	14	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Patent Maker.
11. Industry or business:
FATHER 12. Name: Howard J. Tydings.
FATHER 13. Birthplace: Upper Marlboro, Md.
MOTHER 14. Maiden name: Frances Irene Lucas
MOTHER 15. Birthplace: Waldorf - Md.
18. Informant: Mrs. Howard J. Tydings
Address: Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12 Dec 46 (month) (day) (year)
Cemetery or crematory: Baltimore Memorial
Location: Baltimore, Md.
18. Funeral director: T. B. Hibbert & Son
Address: 1 Sea Isle Place

19. 12 30 46 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 19 46, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute pulmonary Edema.	?
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No
Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Bauer M.D.
acting medical examiner, M. D. or other
Address: Glen Burnie Md. Date signed: 12-28-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11764

Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Bristol, Anne Arundel, Co
City or town: Bristol
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Bristol
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Eliza Waters

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Richard Waters
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	3	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Home

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Ella G. James
Address: 1913 Etting ST. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 7, 1946 (month) (day) (year)
Cemetery or crematory: Moses
Location: Drury, Md.

18. Funeral director: T.A. Hardesty & Son
Address: Galesville, Md.

19. 12/6 1946 (Date rec'd by registrar) W.K. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 Dec 1946, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 July 1945 to 4 Dec 1946 and that I last saw h.er alive on 1 Dec 1946

Immediate cause of death	DURATION
Hypertensive cardio vascular Renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Desmond M. D. or other
Address: Hyattstown Md. Date signed: 5 Dec 46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-a)

CERTIFICATE OF DEATH

11771

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Md
City or town: Forrest Glen (Pasadena R.F.D.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Forrest Glen (Pasadena R.F.D. Md)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William M. Williams.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1893

8. AGE: Years: 53 | Months: 5 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Calvert County, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: William M. Williams
13. Birthplace: Calvert County Md.

MOTHER
14. Maiden name: Mary A. Hayden
15. Birthplace: Calvert County, Md.

16. Informant: Mr. Thomas Hayden Williams.
Address: Forrest Green (Pasadena, R.F.D. Md)

17. Burial (Burial, cremation, or removal, Which?) Date thereof DEC. 21, 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18. Funeral director: Thomas W. Dingletow
Address: Glen Burnie, Md.

19. 12-19 1946 (Date rec'd by registrar) L. A. Bleistein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 1946, at 6.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1939, to Dec. 18 1946
and that I last saw h... alive on Dec. 18 1946

	DURATION
Immediate cause of death: Pulmonary Edema	1 Day
Due to: Bronchitis	2 wks
Due to:	
Other conditions: Chronic osteo-arthritis (Include pregnancy within 3 months of death)	15 yrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. A. Bleistein, M.D.
M. D. or other
Address: Pasadena, Md. Date signed 12-19-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35